FIRST REGULAR SESSION

[P E R F E C T E D**]**

SENATE SUBSTITUTE NO. 2 FOR

SENATE BILL NO. 695

92ND GENERAL ASSEMBLY

Offered April 29, 2003.

Senate Substitute No. 2 adopted, April 29, 2003.

Taken up for Perfection April 29, 2003. Bill declared Perfected and Ordered Printed, as amended.

TERRY L. SPIELER, Secretary.

2016S.07P

AN ACT

To repeal sections 208.010, 208.015, 208.151, 208.152, 208.153, 208.154, 208.156, 208.162, 208.565, 338.501, 338.515, 338.520, 338.525, 338.545, and 338.550, RSMo, and to enact in lieu thereof eleven new sections relating to medical services and eligibility, with an emergency clause.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Sections 208.010, 208.015, 208.151, 208.152, 208.153, 208.154, 208.156, 208.162, 208.565, 338.501, 338.515, 338.520, 338.525, 338.545, and 338.550, RSMo, are repealed and eleven new sections enacted in lieu thereof, to be known as sections 208.010, 208.015, 208.151, 208.152, 208.154, 208.156, 208.162, 208.565, 338.515, 338.520, and 338.550, to read as follows:

208.010. 1. In determining the eligibility of a claimant for public assistance pursuant to this law, it shall be the duty of the division of family services to consider and take into account all facts and circumstances surrounding the claimant, including his or her living conditions, earning capacity, income and resources, from whatever source received, and if from all the facts and circumstances the claimant is not found to be in need, assistance shall be denied. In determining the need of a claimant, the costs of providing medical treatment which may be furnished pursuant to sections 208.151 to 208.158 and 208.162 shall be disregarded. The amount of benefits, when added to all other income, resources, support, and maintenance shall provide such persons with

EXPLANATION--Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

reasonable subsistence compatible with decency and health in accordance with the standards developed by the division of family services; provided, when a husband and wife are living together, the combined income and resources of both shall be considered in determining the eligibility of either or both. "Living together" for the purpose of this chapter is defined as including a husband and wife separated for the purpose of obtaining medical care or nursing home care, except that the income of a husband or wife separated for such purpose shall be considered in determining the eligibility of his or her spouse, only to the extent that such income exceeds the amount necessary to meet the needs (as defined by rule or regulation of the division) of such husband or wife living separately. In determining the need of a claimant in federally aided programs there shall be disregarded such amounts per month of earned income in making such determination as shall be required for federal participation by the provisions of the federal Social Security Act (42 U.S.C.A. 301 et seq.), or any amendments thereto. When federal law or regulations require the exemption of other income or resources, the division of family services may provide by rule or regulation the amount of income or resources to be disregarded.

2. Benefits shall not be payable to any claimant who:

(1) Has or whose spouse with whom he or she is living has, prior to July 1, 1989, given away or sold a resource within the time and in the manner specified in this subdivision. In determining the resources of an individual, unless prohibited by federal statutes or regulations, there shall be included (but subject to the exclusions pursuant to subdivisions (4) and (5) of this subsection, and subsection 5 of this section) any resource or interest therein owned by such individual or spouse within the twenty-four months preceding the initial investigation, or at any time during which benefits are being drawn, if such individual or spouse gave away or sold such resource or interest within such period of time at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits, including but not limited to benefits based on December, 1973, eligibility requirements, as follows:

(a) Any transaction described in this subdivision shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance pursuant to this chapter unless such individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose;

(b) The resource shall be considered in determining eligibility from the date of the transfer for the number of months the uncompensated value of the disposed of resource is divisible by the average monthly grant paid or average Medicaid payment in the state at the time of the investigation to an individual or on his or her behalf under

the program for which benefits are claimed, provided that:

a. When the uncompensated value is twelve thousand dollars or less, the resource shall not be used in determining eligibility for more than twenty-four months; or

b. When the uncompensated value exceeds twelve thousand dollars, the resource shall not be used in determining eligibility for more than sixty months;

(2) The provisions of subdivision (1) of subsection 2 of this section shall not apply to a transfer, other than a transfer to claimant's spouse, made prior to March 26, 1981, when the claimant furnishes convincing evidence that the uncompensated value of the disposed of resource or any part thereof is no longer possessed or owned by the person to whom the resource was transferred;

(3) Has received, or whose spouse with whom he or she is living has received, benefits to which he or she was not entitled through misrepresentation or nondisclosure of material facts or failure to report any change in status or correct information with respect to property or income as required by section 208.210. A claimant ineligible pursuant to this subsection shall be ineligible for such period of time from the date of discovery as the division of family services may deem proper; or in the case of overpayment of benefits, future benefits may be decreased, suspended or entirely withdrawn for such period of time as the division may deem proper;

(4) Owns or possesses resources in the sum of one thousand dollars or more; provided, however, that if such person is married and living with spouse, he or she, or they, individually or jointly, may own resources not to exceed two thousand dollars; and provided further, that in the case of a temporary assistance for needy families claimant, the provision of this subsection shall not apply;

(5) Prior to October 1, 1989, owns or possesses property of any kind or character, excluding amounts placed in an irrevocable prearranged funeral or burial contract pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, or has an interest in property, of which he or she is the record or beneficial owner, the value of such property, as determined by the division of family services, less encumbrances of record, exceeds twenty-nine thousand dollars, or if married and actually living together with husband or wife, if the value of his or her property, or the value of his or her interest in property, together with that of such husband and wife, exceeds such amount;

(6) In the case of temporary assistance for needy families, if the parent, stepparent, and child or children in the home owns or possesses property of any kind or character, or has an interest in property for which he or she is a record or beneficial owner, the value of such property, as determined by the division of family services and

as allowed by federal law or regulation, less encumbrances of record, exceeds one thousand dollars, excluding the home occupied by the claimant, amounts placed in an irrevocable prearranged funeral or burial contract pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, one automobile which shall not exceed a value set forth by federal law or regulation and for a period not to exceed six months, such other real property which the family is making a good-faith effort to sell, if the family agrees in writing with the division of family services to sell such property and from the net proceeds of the sale repay the amount of assistance received during such period. If the property has not been sold within six months, or if eligibility terminates for any other reason, the entire amount of assistance paid during such period shall be a debt due the state;

(7) Is an inmate of a public institution, except as a patient in a public medical institution.

3. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the income and resources of a relative or other person living in the home shall be taken into account to the extent the income, resources, support and maintenance are allowed by federal law or regulation to be considered.

4. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the value of burial lots or any amounts placed in an irrevocable prearranged funeral or burial contract pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, shall not be taken into account or considered an asset of the burial lot owner or the beneficiary of an irrevocable prearranged funeral or funeral contract. For purposes of this section, "burial lots" means any burial space as defined in section 214.270, RSMo, and any memorial, monument, marker, tombstone or letter marking a burial space. If the beneficiary, as defined in chapter 436, RSMo, of an irrevocable prearranged funeral or burial contract receives any public assistance benefits pursuant to this chapter and if the purchaser of such contract or his or her successors in interest cancel or amend the contract so that any person will be entitled to a refund, such refund shall be paid to the state of Missouri up to the amount of public assistance benefits provided pursuant to this chapter with any remainder to be paid to those persons designated in chapter 436, RSMo.

5. In determining the total property owned pursuant to subdivision (5) of subsection 2 of this section, or resources, of any person claiming or for whom public assistance is claimed, there shall be disregarded any life insurance policy, or prearranged funeral or burial contract, or any two or more policies or contracts, or any

combination of policies and contracts, which provides for the payment of one thousand five hundred dollars or less upon the death of any of the following:

(1) A claimant or person for whom benefits are claimed; or

(2) The spouse of a claimant or person for whom benefits are claimed with whom he or she is living.

If the value of such policies exceeds one thousand five hundred dollars, then the total value of such policies may be considered in determining resources; except that, in the case of temporary assistance for needy families, there shall be disregarded any prearranged funeral or burial contract, or any two or more contracts, which provides for the payment of one thousand five hundred dollars or less per family member.

6. Beginning September 30, 1989, when determining the eligibility of institutionalized spouses, as defined in 42 U.S.C. Section 1396r-5, for medical assistance benefits as provided for in section 208.151 and 42 U.S.C. Sections 1396a et seq., the division of family services shall comply with the provisions of the federal statutes and regulations. As necessary, the division shall by rule or regulation implement the federal law and regulations which shall include but not be limited to the establishment of income and resource standards and limitations. The division shall require:

(1) That at the beginning of a period of continuous institutionalization that is expected to last for thirty days or more, the institutionalized spouse, or the community spouse, may request an assessment by the division of family services of total countable resources owned by either or both spouses;

(2) That the assessed resources of the institutionalized spouse and the community spouse may be allocated so that each receives an equal share;

(3) That upon an initial eligibility determination, if the community spouse's share does not equal at least twelve thousand dollars, the institutionalized spouse may transfer to the community spouse a resource allowance to increase the community spouse's share to twelve thousand dollars;

(4) That in the determination of initial eligibility of the institutionalized spouse, no resources attributed to the community spouse shall be used in determining the eligibility of the institutionalized spouse, except to the extent that the resources attributed to the community spouse do exceed the community spouse's resource allowance as defined in 42 U.S.C. Section 1396r-5;

(5) That beginning in January, 1990, the amount specified in subdivision (3) of this subsection shall be increased by the percentage increase in the consumer price index for all urban consumers between September, 1988, and the September before the calendar year involved; and

(6) That beginning the month after initial eligibility for the institutionalized spouse is determined, the resources of the community spouse shall not be considered available to the institutionalized spouse during that continuous period of institutionalization.

7. Beginning July 1, 1989, institutionalized individuals shall be ineligible for the periods required and for the reasons specified in 42 U.S.C. Section 1396p.

8. The hearings required by 42 U.S.C. Section 1396r-5 shall be conducted pursuant to the provisions of section 208.080.

9. Beginning October 1, 1989, when determining eligibility for assistance pursuant to this chapter there shall be disregarded unless otherwise provided by federal or state statutes, the home of the applicant or recipient when the home is providing shelter to the applicant or recipient, or his or her spouse or dependent child. The division of family services shall establish by rule or regulation in conformance with applicable federal statutes and regulations a definition of the home and when the home shall be considered a resource that shall be considered in determining eligibility.

10. Reimbursement for services provided by an enrolled Medicaid provider to a recipient who is duly entitled to Title XIX Medicaid and Title XVIII Medicare Part B, Supplementary Medical Insurance (SMI) shall include payment in full of deductible and coinsurance amounts as determined due pursuant to the applicable provisions of federal regulations pertaining to Title XVIII Medicare Part B, except the applicable Title XIX cost sharing.

11. A "community spouse" is defined as being the noninstitutionalized spouse.

208.015. 1. The division of family services shall grant general relief benefits to those persons determined to be eligible under this chapter and the applicable rules of the division. The director may adopt such additional requirements for eligibility for general relief, not inconsistent with this chapter, which he deems appropriate.

2. General relief shall not be granted to any person:

(1) Who has been approved for federal supplemental security income and was not on the general relief rolls in December, 1973; or

(2) Who is a recipient of:

(a) Aid to families with dependent children benefits;

(b) Aid to the blind benefits;

(c) Blind pension benefits; or

(d) Supplemental aid to the blind benefits.

3. A person shall not be considered unemployable, under this section, if unemployability is due to school attendance.

4. Persons receiving general relief in December, 1973, and who qualify for supplemental security income shall continue to receive a general relief grant if necessary to prevent a reduction in the total cash income received by such person in December, 1973, which general relief grant shall not exceed the amount of general relief provided by law.

5. In providing benefits to persons applying for or receiving general relief, benefits shall not be provided to any member of a household if the claimant is employable as defined by rule of the division of family services; or if certain specified relatives living in the household of the claimant are employed and have income sufficient to support themselves and their legal dependents and to meet the needs of the claimant as defined by rule of the division. "Specified relatives" shall be defined as the spouse, mother, father, sister, brother, son, daughter, and grandparents of the claimant, as well as the spouses of these relatives, if living in the home.

6. General relief paid to an unemployable person shall not exceed one hundred dollars a month.

7. Notwithstanding any other provision of law to the contrary, services pursuant to section 208.015 may be provided if appropriations are made available. If in any given year monies are not appropriated to fund the services set out in section 208.015, such services shall not be provided and persons otherwise eligible for services will no longer be deemed eligible.

208.151. 1. For the purpose of paying medical assistance on behalf of needy persons and to comply with Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301 et seq.) as amended, the following needy persons shall be eligible to receive medical assistance to the extent and in the manner hereinafter provided:

(1) All recipients of state supplemental payments for the aged, blind and disabled;

(2) All recipients of aid to families with dependent children benefits, including all persons under nineteen years of age who would be classified as dependent children except for the requirements of subdivision (1) of subsection 1 of section 208.040;

(3) All recipients of blind pension benefits;

(4) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits under the eligibility standards in effect December 31, 1973, or less restrictive standards as established by rule of the division of family services, who are sixty-five years of age or over and are patients in state institutions for mental diseases or tuberculosis;

(5) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children except for the requirements of subdivision (2) of subsection 1 of section 208.040, and who are residing in an intermediate care facility, or receiving active treatment as inpatients in psychiatric facilities or programs, as defined in 42 U.S.C. 1396d, as amended;

(6) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children benefits except for the requirement of deprivation of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(7) All persons eligible to receive nursing care benefits;

(8) All recipients of family foster home or nonprofit private child-care institution care, subsidized adoption benefits and parental school care wherein state funds are used as partial or full payment for such care;

(9) All persons who were recipients of old age assistance benefits, aid to the permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who continue to meet the eligibility requirements, except income, for these assistance categories, but who are no longer receiving such benefits because of the implementation of Title XVI of the federal Social Security Act, as amended;

(10) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child in the home;

(11) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child who is deprived of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(12) Pregnant women or infants under one year of age, or both, whose family income does not exceed an income eligibility standard equal to one hundred eighty-five percent of the federal poverty level as established and amended by the federal Department of Health and Human Services, or its successor agency;

(13) Children who have attained one year of age but have not attained six years of age who are eligible for medical assistance under 6401 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The division of family services shall use an income eligibility standard equal to one hundred thirty-three percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency;

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of age, the division of family services shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department

of Health and Human Services, or its successor agency. As necessary to provide Medicaid coverage under this subdivision, the department of social services may revise the state Medicaid plan to extend coverage under 42 U.S.C. 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42 U.S.C. 1396a;

(15) The following children with family income which does not exceed two hundred percent of the federal poverty guideline for the applicable family size:

(a) Infants who have not attained one year of age with family income greater than one hundred eighty-five percent of the federal poverty guideline for the applicable family size;

(b) Children who have attained one year of age but have not attained six years of age with family income greater than one hundred thirty-three percent of the federal poverty guideline for the applicable family size; and

(c) Children who have attained six years of age but have not attained nineteen years of age with family income greater than one hundred percent of the federal poverty guideline for the applicable family size.

Coverage under this subdivision shall be subject to the receipt of notification by the director of the department of social services and the revisor of statutes of approval from the secretary of the U.S. Department of Health and Human Services of applications for waivers of federal requirements necessary to promulgate regulations to implement this subdivision. The director of the department of social services shall apply for such waivers. The regulations may provide for a basic primary and preventive health care services package, not to include all medical services covered by section 208.152, and may also establish co-payment, coinsurance, deductible, or premium requirements for medical assistance under this subdivision. Eligibility for medical assistance under this subdivision shall be available only to those infants and children who do not have or have not been eligible for employer-subsidized health care insurance coverage for the six months prior to application for medical assistance. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The division of family services may establish a resource eligibility standard in assessing eligibility for persons under this subdivision. The division of medical services shall define the amount and scope of benefits which are available to individuals under this subdivision in accordance with the requirement of federal law and regulations. Coverage under this subdivision shall be subject to appropriation to provide

services approved under the provisions of this subdivision;

(16) The division of family services shall not establish a resource eligibility standard in assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The division of medical services shall define the amount and scope of benefits which are available to individuals eligible under each of the subdivisions (12), (13), and (14) of this subsection, in accordance with the requirements of federal law and regulations promulgated thereunder except that the scope of benefits shall include case management services;

(17) Notwithstanding any other provisions of law to the contrary, ambulatory prenatal care shall be made available to pregnant women during a period of presumptive eligibility pursuant to 42 U.S.C. Section 1396r-1, as amended;

(18) A child born to a woman eligible for and receiving medical assistance under this section on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of time determined in accordance with applicable federal and state law and regulations so long as the child is a member of the woman's household and either the woman remains eligible for such assistance or for children born on or after January 1, 1991, the woman would remain eligible for such assistance if she were still pregnant. Upon notification of such child's birth, the division of family services shall assign a medical assistance eligibility identification number to the child so that claims may be submitted and paid under such child's identification number;

(19) Pregnant women and children eligible for medical assistance pursuant to subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for medical assistance benefits be required to apply for aid to families with dependent children. The division of family services shall utilize an application for eligibility for such persons which eliminates information requirements other than those necessary to apply for medical assistance. The division shall provide such application forms to applicants whose preliminary income information indicates that they are ineligible for aid to families with dependent children. Applicants for medical assistance benefits under subdivision (12), (13) or (14) shall be informed of the aid to families with dependent children program and that they are entitled to apply for such benefits. Any forms utilized by the division of family services for assessing eligibility under this chapter shall be as simple as practicable;

(20) Subject to appropriations necessary to recruit and train such staff, the division of family services shall provide one or more full-time, permanent case workers

to process applications for medical assistance at the site of a health care provider, if the health care provider requests the placement of such case workers and reimburses the division for the expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment, of such case workers. The division may provide a health care provider with a part-time or temporary case worker at the site of a health care provider if the health care provider requests the placement of such a case worker and reimburses the division for the expenses, including but not limited to the salary, benefits, travel, training, telephone, supplies, and equipment, of such a case worker. The division may seek to employ such case workers who are otherwise qualified for such positions and who are current or former welfare recipients. The division may consider training such current or former welfare recipients as case workers for this program;

(21) Pregnant women who are eligible for, have applied for and have received medical assistance under subdivision (2), (10), (11) or (12) of this subsection shall continue to be considered eligible for all pregnancy-related and postpartum medical assistance provided under section 208.152 until the end of the sixty-day period beginning on the last day of their pregnancy;

(22) Case management services for pregnant women and young children at risk shall be a covered service. To the greatest extent possible, and in compliance with federal law and regulations, the department of health and senior services shall provide case management services to pregnant women by contract or agreement with the department of social services through local health departments organized under the provisions of chapter 192, RSMo, or chapter 205, RSMo, or a city health department operated under a city charter or a combined city-county health department or other department of health and senior services designees. To the greatest extent possible the department of social services and the department of health and senior services shall mutually coordinate all services for pregnant women and children with the crippled children's program, the prevention of mental retardation program and the prenatal care program administered by the department of health and senior services. The department of social services shall by regulation establish the methodology for reimbursement for case management services provided by the department of health and senior services. For purposes of this section, the term "case management" shall mean those activities of local public health personnel to identify prospective Medicaid-eligible high-risk mothers and enroll them in the state's Medicaid program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who participate in the Medicaid program for prenatal care and to ensure that said high-risk mothers receive support from all private and public programs for which they are eligible

and shall not include involvement in any Medicaid prepaid, case-managed programs;

(23) By January 1, 1988, the department of social services and the department of health and senior services shall study all significant aspects of presumptive eligibility for pregnant women and submit a joint report on the subject, including projected costs and the time needed for implementation, to the general assembly. The department of social services, at the direction of the general assembly, may implement presumptive eligibility by regulation promulgated pursuant to chapter 207, RSMo;

(24) All recipients who would be eligible for aid to families with dependent children benefits except for the requirements of paragraph (d) of subdivision (1) of section 208.150;

(25) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits, under the eligibility standards in effect December 31, 1973; except that, on or after July 1, 2002, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to eighty percent of the federal poverty level and, as of July 1, 2003, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to ninety percent of the federal poverty level and, as of July 1, 2004, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal poverty level. If federal law or regulation authorizes the division of family services to, by rule, exclude the income or resources of a parent or parents of a person under the age of eighteen and such exclusion of income or resources can be limited to such parent or parents, then notwithstanding the provisions of section 208.010:

(a) The division may by rule exclude such income or resources in determining such person's eligibility for permanent and total disability benefits; and

(b) Eligibility standards for permanent and total disability benefits shall not be limited by age; **notwithstanding any other provision of law to the contrary, if in any given fiscal year monies are not appropriated for coverage of medical assistance for persons whose income, calculated using less restrictive income methodologies, as authorized in 42 U.S.C. section 1396(r)(2), exceeds eighty percent of the federal poverty level, those persons will not be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits in that fiscal year.**

(26) Within thirty days of the effective date of an initial appropriation authorizing medical assistance on behalf of "medically needy" individuals for whom

federal reimbursement is available under 42 U.S.C. 1396a (a)(10)(c), the department of social services shall submit an amendment to the Medicaid state plan to provide medical assistance on behalf of, at a minimum, an individual described in subclause (I) or (II) of clause 42 U.S.C. 1396a (a)(10)(C)(ii);

(27) Persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage pursuant to 42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. 1396r-1.

2. Rules and regulations to implement this section shall be promulgated in accordance with section 431.064, RSMo, and chapter 536, RSMo. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.

3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for medical assistance for four calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for medical assistance for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C. 1396r-6. Each family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. 1396r-6 shall receive medical assistance without fee for an additional six months. The division of medical services may provide by rule the scope of medical assistance coverage to be granted to such families.

4. For purposes of Section 1902(1), (10) of Title XIX of the federal Social Security Act, as amended, any individual who, for the month of August, 1972, was eligible for or was receiving aid or assistance pursuant to the provisions of Titles I, X, XIV, or Part A of Title IV of such act and who, for such month, was entitled to monthly insurance benefits under Title II of such act, shall be deemed to be eligible for such aid or assistance for such month thereafter prior to October, 1974, if such individual would have been eligible for such aid or assistance for such month had the increase in monthly insurance benefits under Title II of such act resulting from enactment of Public Law 92-336 amendments to the federal Social Security Act (42 U.S.C. 301 et seq.), as amended, not been applicable to such individual.

5. When any individual has been determined to be eligible for medical assistance, such medical assistance will be made available to him for care and services furnished in or after the third month before the month in which he made application for such assistance if such individual was, or upon application would have been, eligible for such assistance at the time such care and services were furnished; provided, further, that such medical expenses remain unpaid.

6. The department of social services may apply to the federal Department of Health and Human Services for a Medicaid waiver amendment to the Section 1115 demonstration waiver or for any additional Medicaid waivers necessary and desirable to implement the increased income limit, as authorized in subdivision (25) of subsection 1 of this section.

208.152. 1. Benefit payments for medical assistance shall be made on behalf of those eligible needy persons who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the division of medical services, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the division of medical services shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the Medicaid children's diagnosis length-of-stay schedule; and provided further that the division of medical services shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary

charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the division of medical services may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the division of medical services not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for recipients, except to persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the division of aging or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX, of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The division of medical services may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of Medicaid patients. The division of medical services when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for recipients of benefit payments under subdivision (4) of this section for those days, which shall not exceed twelve per any period of six consecutive months, during which the recipient is on a temporary leave of absence from the hospital or nursing home, provided that no such recipient shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a recipient is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(7) Dental services;

(8) Services of podiatrists as defined in section 330.010, RSMo;

(9) **[**Drugs and medicines when prescribed by a licensed physician, dentist, or podiatrist;**]** **Prescription and non-prescription drugs and items directly related to the administration of prescription and nonprescription drugs prescribed by a health care professional authorized in his state of residence to issue a**

prescription, and approved by the division of medical services. Such drugs and items shall be approved for safety and effectiveness pursuant to section 505 or 507 of the Federal Food, Drug and Cosmetic Act;

(10) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments. The department of social services may conduct demonstration projects related to the provision of medically necessary transportation to recipients of medical assistance under this chapter. Such demonstration projects shall be funded only by appropriations made for the purpose of such demonstration projects. If funds are appropriated for such demonstration projects, the department shall submit to the general assembly a report on the significant aspects and results of such demonstration projects;

(11) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of section 6403 of P.L.53 101-239 and federal regulations promulgated thereunder;

(12) Home health care services;

(13) Optometric services as defined in section 336.010, RSMo;

(14) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician to the Medicaid agency that, in his professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(15) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(16) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. 1396d, et seq.);

(17) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(18) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which

enable a person to be treated by his physician on an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the recipient's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one recipient one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time;

(19) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, "mental health professional" and "alcohol and drug abuse professional" shall be defined by the department of mental

health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, division of medical services, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the division of medical services. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(20) Comprehensive day rehabilitation services beginning early **[**posttrauma**]** **post-trauma** as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive and behavioral function. The division of medical services shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism;

(21) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. Beginning July 1, 1990, the rate of reimbursement paid by the division of medical services to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(22) Such additional services as defined by the division of medical services to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. 301, et seq.) subject to appropriation by the general assembly;

(23) Beginning July 1, 1990, the services of a certified pediatric or family nursing practitioner to the extent that such services are provided in accordance with chapter 335, RSMo, and regulations promulgated thereunder, regardless of whether the nurse practitioner is supervised by or in association with a physician or other health care provider;

(24) Subject to appropriations, the department of social services shall conduct demonstration projects for **[**nonemergency**]** **non-emergency**, physician-prescribed transportation for pregnant women who are recipients of medical assistance under this chapter in counties selected by the director of the division of medical services. The funds appropriated pursuant to this subdivision shall be used for the purposes of this subdivision and for no other purpose. The department shall not fund such demonstration projects with revenues received for any other purpose. This subdivision shall not authorize transportation of a pregnant woman in active labor. The division of medical services shall notify recipients of **[**nonemergency**]** **non-emergency** transportation services under this subdivision of such other transportation services which may be appropriate during active labor or other medical emergency;

(25) Nursing home costs for recipients of benefit payments under subdivision (4) of this subsection to reserve a bed for the recipient in the nursing home during the time that the recipient is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of Medicaid certified licensed beds, according to the most recent quarterly census provided to the division of aging which was taken prior to when the recipient is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a recipient pursuant to this subdivision during any period of six consecutive months such recipient shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the recipient or the recipient's responsible party that the recipient

intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the recipient or the recipient's responsible party prior to release of the reserved bed.

(26) Notwithstanding any other provision of law to the contrary, services pursuant to sections 208.152.1(1) through (25) may be provided if appropriations are made available for such services. If any given year monies are not appropriated to fund one or more services set out in sections 208.152.1(1) through (25), such services shall not be provided and persons otherwise eligible for services will no longer be deemed eligible.

2. Benefit payments for medical assistance for surgery as defined by rule duly promulgated by the division of medical services, and any costs related directly thereto, shall be made only when a second medical opinion by a licensed physician as to the need for the surgery is obtained prior to the surgery being performed.

3. The division of medical services may require any recipient of medical assistance to pay part of the charge or cost, as defined by rule **or emergency rule** duly promulgated by the division of medical services, for dental services, drugs and medicines, optometric services, eye glasses, dentures, hearing aids, and other services, to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, RSMo, and a generic drug is substituted for a name brand drug, the division of medical services may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all recipients the partial payment that may be required by the division of medical services under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by recipients under this section shall be in addition to, and not in lieu of, any payments made by the state for goods or services described herein.

4. The division of medical services shall have the right to collect medication samples from recipients in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for medical assistance at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42

U.S.C. 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for medical assistance under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the Medicaid program shall not increase payments in excess of the increase that would result from the application of section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a (a)(13)(C).

10. The department of social services, division of medical services, may enroll qualified residential care facilities, as defined in chapter 198, RSMo, as Medicaid personal care providers.

208.154. **[**If the funds at the disposal or which may be obtained by the division of family services**]** **Notwithstanding any provision of law to the contrary, if the funds available to the department of social services and its divisions** for the payment of public assistance **[**money payment**]** benefits or to or on behalf of any person for medical assistance benefits shall at any time become insufficient to pay the full amount thereof, the amount of any type of payment to or on behalf of each of such persons **[**shall**]** **may** be reduced pro rata **[**in proportion to such deficiency in the total amount available or to become available for such purpose.**]** **during the final six months of the fiscal year. Resources available shall be documented by the moneys appropriated by law for the above purpose, less actions by the governor pursuant to article IV, sections 26 and 27 of the Missouri Constitution and section 33.290, RSMo.**

208.156. 1. The **[**division of family services**]** **department of social services**

and its divisions shall provide for granting an opportunity for a fair hearing under section 208.080 to any applicant or recipient whose claim for medical assistance is denied or is not acted upon with reasonable promptness.

2. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 whose claim for reimbursement for such services is denied or is not acted upon with reasonable promptness shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

3. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 who is denied participation in any program or programs established under the provisions of chapter 208 shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

4. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 who is aggrieved by any rule or regulation promulgated by the department of social services or any division therein shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

5. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 who is aggrieved by any rule or regulation, contractual agreement, or decision, as provided for in section 208.166, by the department of social services or any division therein shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

6. No provider of service may file a petition for a hearing before the administrative hearing commission unless the amount for which he seeks reimbursement exceeds five hundred dollars.

7. One or more providers of service as will fairly insure adequate representation of others having similar claims against the department of social services or any division therein may institute the hearing on behalf of all in the class if there is a common question of law or fact affecting the several rights and a common relief is sought.

8. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 and who is entitled to a hearing as provided for in the preceding sections shall have thirty days from the date of mailing or delivery of a decision of the department of social services or its designated division in which to file his petition for review with the administrative hearing commission except that claims of less than five hundred dollars may be accumulated until they total that

sum and at which time the provider shall have ninety days to file his petition.

9. When a person entitled to a hearing as provided for in this section applies to the administrative hearing commission for a stay order staying the actions of the department of social services or its divisions, the administrative hearing commission shall not grant such stay order until after a full hearing on such application. The application shall be advanced on the docket for immediate hearing and determination. The person applying for such stay order shall not be granted such stay order unless that person shall show that immediate and irreparable injury, loss, or damage will result if such stay order is denied, or that such person has a reasonable likelihood of success upon the merits of his claim; and provided further that no stay order shall be issued without the person seeking such order posting a bond in such sum as the administrative hearing commission finds sufficient to protect and preserve the interest of the department of social services or its divisions. In no event may the administrative hearing commission grant such stay order where the claim arises under a program or programs funded by federal funds or by any combination of state and federal funds, unless it is specified in writing by the financial section of the appropriate federal agency that federal financial participation will be continued under the stay order.

10. The other provisions of this section notwithstanding, a person receiving or providing benefits shall have the right to bring an action in appealing from the administrative hearing commission in the circuit court of Cole County, Missouri, or the county of his residence pursuant to section 536.050, RSMo.

208.162. 1. Benefit payments for medical assistance shall be made on behalf of those individuals who are receiving general relief benefits under section 208.015**, or would have been eligible for general relief benefits as defined on June 30, 2003**, with any payments to be made on the basis of reasonable cost of the care or reasonable charge for the services as defined and determined by the division of family services, for the following, provided that the division of family services may negotiate a rate of payment for hospital services different than the Medicare rate for such services:

(1) Inpatient hospital services, including the first three pints of whole blood unless available to the patient from other sources; provided, that in the case of eligible persons who are provided benefits under Title XVIII A, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C.A. section 301 et seq.), as amended, payment for the first ninety days during any spell of illness shall not exceed the cost of any deductibles imposed by such title, plus coinsurance after the first sixty days;

(2) All outpatient hospital services, including diagnostic services; provided,

however, that the division of family services shall evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the division of family services not to be medically necessary;

(3) Laboratory and X-ray services;

(4) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(5) Drugs and medicines when prescribed by a licensed physician;

(6) Emergency ambulance services;

(7) Any other services provided under section 208.152, to the extent and in the manner as defined and determined by the division of family services.

2. The division of family services shall have the right to collect medication samples from recipients in order to maintain program integrity.

3. Payments shall be prorated within the limits of the appropriation.

4. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024, RSMo.

208.565. 1. The division shall negotiate with manufacturers for participation in the program. The division shall issue a certificate of participation to pharmaceutical manufacturers participating in the Missouri Senior Rx program. A pharmaceutical manufacturer may apply for participation in the program with an application form prescribed by the commission. A certificate of participation shall remain in effect for an initial period of not less than one year and shall be automatically renewed unless terminated by either the manufacturer or the state with sixty days' notification.

2. **For all transactions occurring prior to July 1, 2003, the rebate amount for each drug shall be fifteen percent of the average manufacturers' price as defined pursuant to 42 U.S.C. 1396r-8(k)(1). For all transactions occurring on or after July 1, 2003,** the rebate amount for **[**each drug**] name brand prescription drugs** shall be fifteen percent **and the rebate amount for generic prescription drugs shall be eleven percent** of the average manufacturers' price as defined pursuant to 42 U.S.C. 1396r-8(k)(1). No other discounts shall apply. In order to receive a certificate of participation a manufacturer or distributor participating in the Missouri Senior Rx program shall provide the division of aging the average manufacturers' price for their contracted products. The following shall apply to the providing of average manufacturers' price information to the division of aging:

(1) Any manufacturer or distributor with an agreement under this section that knowingly provides false information is subject to a civil penalty in an amount not to

exceed one hundred thousand dollars for each provision of false information. Such penalties shall be in addition to other penalties as prescribed by law;

(2) Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers pursuant to this subsection or under an agreement with the division pursuant to this section is confidential and shall not be disclosed by the division or any other state agency or contractor therein in any form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler, except to permit the state auditor to review the information provided and the division of medical services for rebate administration.

3. All rebates received through the program shall be used toward refunding the program. If a pharmaceutical manufacturer refuses to participate in the rebate program, such refusal shall not affect the manufacturer's status under the current Medicaid program. There shall be no drug formulary, prior approval system, or any similar restriction imposed on the coverage of outpatient drugs made by pharmaceutical manufacturers who have agreements to pay rebates for drugs utilized in the Missouri Senior Rx program, provided that such outpatient drugs were approved by the Food and Drug Administration.

4. Any prescription drug of a manufacturer that does not participate in the program shall not be reimbursable.

338.515. **[**The tax imposed by sections 338.500 to 338.550 shall become effective July 1, 2002, or the effective date of sections 338.500 to 338.550, whichever is later**]** **The tax imposed by sections 338.500 to 338.550 shall become effective July 1, 2003, or the effective date of sections 338.500 to 338.550, whichever is later**.

338.520. 1. The determination of the amount of tax due shall be the monthly gross retail prescription receipts reported to the department of revenue multiplied by the tax rate established by rule by the department of social services. Such tax rate may be a graduated rate based on gross retail prescription receipts and shall not exceed a rate of six percent per annum of gross retail prescription receipts; provided, that such rate shall not exceed one-tenth of one percent per annum in the case of licensed pharmacies of which eighty percent or more of such gross receipts are attributable to prescription drugs that are delivered directly to the patient via common carrier, by mail, or a courier service.

2. The department of social services shall notify each licensed retail pharmacy of the amount of tax due. Such amount may be paid in increments over the balance of the assessment period.

3. The department of social services may adjust the application of the

tax rate quarterly on a prospective basis consistent with subsection 1 of this section. The department of social services may adjust more frequently for individual providers if there is a substantial and statistically significant change in their pharmacy sales characteristics. The department of social services may define such adjustment criteria by rule.

338.550. 1. **[**The pharmacy tax required by sections 338.500 to 338.550 shall be the subject of an annual health care cost impact study commissioned by the department of insurance to be completed prior to or on January 1, 2003, and each year the tax is in effect. The report shall be submitted to the speaker of the house, president pro tem of the senate, and the governor. This study shall employ an independent economist and an independent actuary paid for by the state's department of social services. The department shall seek the advice and input from the department of social services, business health care purchasers, as well as health care insurers in the selection of the economist and actuary. This study shall assess the degree of health care costs shifted to individual Missourians and individual and group health plans resulting from this tax.

2.**]** The provisions of sections 338.500 to 338.550 shall not apply to pharmacies domiciled or headquartered outside this state which are engaged in prescription drug sales that are delivered directly to patients within this state via common carrier, mail or a carrier service.

[3.**]** **2.** Sections 338.500 to 338.550 shall expire on June 30, **[**2003**]** **2006**.

[338.501. In fiscal year 2003, the amount generated by the tax imposed pursuant to section 338.500, less any amount paid pursuant to section 338.545, shall be used in the formula necessary to qualify for the calculations included in house bill 1102, section 2.325 through section 2.333 as passed by the ninety-first general assembly, second regular session.**]**

[338.525. If a pharmacy's gross retail prescription receipts are included in the revenue assessed by the federal reimbursement allowance or the nursing facility reimbursement allowance, the proportion of those taxes paid or the entire tax due shall be allowed as a credit for the pharmacy tax due pursuant to section 338.500.**]**

[338.545. 1. The Medicaid pharmacy dispensing fee shall be adjusted to include a supplemental payment amount equal to the tax assessment due plus ten percent.

2. The amount of the supplemental payment shall be adjusted once annually beginning July first or once annually after the initial start date

of the pharmacy tax, whichever is later.

3. If the pharmacy tax required by sections 338.500 to 338.550 is declared invalid, the pharmacy dispensing fee for the Medicaid program shall be the same as the amount required on July 1, 2001.**]**

Section B. Because of the need to balance the state budget, section A of this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and section A of this act shall be in full force and effect upon its passage and approval.

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